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To acquire information concerning the counselor's feelings and ideas about his profession, about himself as a professional practitioner in the field of rehabilitation, and about the organizational structure within which he is employed, data were collected by questionnaire from 114 counselors in the New England State Rehabilitation Agencies. Results showed that the rehabilitation counselor in the state agency classified himself as either (1) a type of psychotherapist with the responsibility of helping the disabled person achieve an adequate total life adjustment, or (2) a manipulator of the environment with the major goal being return of the client to employment. The personal self image was one of low prestige, evidenced by the fact that 40 percent of the rehabilitation counselors sampled indicated they would leave the profession if they could. These findings cannot be generalized to counselors in other parts of the United States; however, with reference to New England counselors, there is certainly room for concern if the results of this study are viewed in the light of the counselor's ability to motivate his clients. Further research is needed on the role of the vocational rehabilitation counselor in the state agency and on the training and administrative climate in which he works. (CH)

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A Study of Factors Influencing Counselor Motivation in the Six New England State Rehabilitation Agencies.

by

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PREFACE

It is common knowledge among professionals in the field of rehabilitation that some individuals with severe disabilities become successfully rehabilitated to live meaningful and productive lives, while others far less handicapped are unsuccessful in achieving this goal. Success or failure in rehabilitation depends to a large extent upon client motivation and the manner in which dependent strivings are handled. Knowledge of client motivation and dependency is elusive indeed. This is because both motivation and dependency are configurations or constellations of attributes rather than unitary traits. Yet this knowledge is of such crucial importance that client motivation and dependency has been adopted as the core research area of the New England Rehabilitation Research Institute. A detailed discussion of the problems and progress in researching motivation and dependency is included in New England Rehabilitation Research Institute Monograph No. 1.

Although the Institute is chiefly interested in research which is client centered, it nevertheless recognizes that social systems external to the client influence his motivation and his dependent relationships. Therefore, these systems have been studied by the New England Rehabilitation Research Institute to learn how they affect the motivation of the client in rehabilitation.

The study which follows investigated the motivations of rehabilitation counselors. It is predicated on the hypothesis that the motivations of professionals profoundly influence the motivation and dependent behavior of the handicapped individuals whom they attempt to help.

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INTRODUCTION

There can be little doubt that the rehabilitation counselor in the state agency is a pivotal helping person in the rehabilitation process. To him falls the responsibility for carrying out the four major activities which comprise the counselor's role: diagnosis of the rehabilitation problem; assistance to the client in the development of a rehabilitation treatment plan; mobilization and coordination of the community's health, welfare, educational, and vocational services in the client's behalf; and emotional support of the client during the entire process, particularly during the more stressful periods.

If the client is to participate meaningfully and successfully in these activities, he must be maintained in a reasonably high state of motivation. To most effectively help the client achieve an adequate level of motivation, the rehabilitation counselor must himself be well motivated. Recent studies (20, 21) have shown that in industrial tasks there is not necessarily a direct relationship between morale and productivity. However, in the case of the helping professions, the practitioner's feelings about his profession, his professional self-image, and his attitudes toward his employing organization can influence his ability to motivate his clients.

Certain psychodynamic configurations within the personality system of the counselor form a part of his own motivational structure and profoundly influence his ability to counsel the handicapped client effectively. The manner in which these configurations are expressed (positively or negatively) depends to a large extent upon the style of supervision to which the counselor is exposed and the stresses and tensions which exist within the agency's organizational system.

In the following analysis of the problem, Stotsky (41) points out clearly and succinctly some of the pitfalls which are possible if counselor and supervisor are not aware of their own motivations relative to their clients, their peer group, and their superiors. Dr. Stotsky states:

> In response to client distortions or to his personal needs, unresolved problems, and discomfort, the counselor may react in a personal and emotional manner. The client will frequently provoke this reaction by a subtle unconscious cue or may even deliberately bring it about. At such times the counterreaction of the counselor, by providing confirmation in reality of the unexpressed expectations of the client, gives some justification to the regressive behavior of the client. The same, in lesser degree, holds true for the supervisor-counselor relationship. Little difficulties, tension, and impasses arise which, while reflecting personal problems,

subtly influence the relationship and divert attention from the problems the two are trying to help solve. This diversion operates in the service of the client's resistance to change and prevents effective action in dealing with the dependency problem. Neither the counselor nor the supervisor needs to be analyzed to overcome these distortions. However, they must be alert to the presence of these distortions, particularly in themselves. What are they?

1. Gratification of one's own needs for self aggandizement by keeping client dependent upon counselor, or counselor on supervisor.
2. The wish to play God or omnipotent, beneficent father.
3. Fear of taking or encouraging others to take risks lest failure reflect unfavorably on your self-esteem.
4. Overidentification with client or counselor.
5. Imposition of one's own personal values on others or on the situation itself. As it is, the client often identifies with the values of the counselor.
6. The client or the counselor may remind the supervisor favorably or unfavorably of some affectively important person in his life. Supervisor may react to client or to counselor as he would to this significant figure.
7. Counselor or supervisor may entertain stereotyped attitudes or prejudices to the group of which the client is a member. These may in turn influence the latter's response. Reactions may occur both ways to the stereotype rather than to the true person.
8. Supervisor may pursue certain points raised by client with counselor in a compulsive manner, regardless of their appropriateness to the problem. The supervisor may ride his own hobby horses and pet projects in a similar manner.
9. Having achieved a level of stability in his relationship with the client, the counselor may be unwilling to disturb the equilibrium of the patient. The supervisor may feel it is unwise to disturb this equilibrium even though no progress is being made to resolve the dependency impasse.
10. Situational factors in the counselor's or supervisor's life, e.g. domestic difficulties, may influence his thinking and actions in a manner unsuitable to the present relationship.
11. Ethical, moral, and religious questions, which may not be applicable in this particular situation, may influence the counselor or supervisor's judgment and behavior. In some instances, they may also restrain him from confronting the client with evidence that he is resisting change.
12. Fear of loss of the patient's respect or approval should he challenge patient.
13. Excessive identification with the underdog regardless of the merits of the latter's position.

14. The manner by which the counselor structures his role as representative of the agency-social agent, giver or withholder, etc. View of client as helpless, social orphan or as deceitful person, intent on fooling the agency. This category is less applicable to the supervisor-counselor relationship, but even there the role prescriptions are not so fixed that deviations or distortions do not occur.
15. Degree of interest in objectivity may be low. This again demonstrates the need for a detached observer, a view by a third man into the relationship.
16. Conflict within counselor or supervisor as to whether he is a "company" man or advocate for the client. Role may tend to become marginal and with the loss of objectivity comes the temptation to move in one or the other direction. The supervisor in particular may have strong inhibitions against enforcing the rules and policies of the agency if, in doing so, he loses the "nice guy" self-image.
17. Seeing counselor as a threat or rival. This is accentuated if supervisor has doubts about his own capacity or wonders if his counselor is more knowledgeable than he.
18. Just as the client may delight in playing on the counselor's weaknesses and anxieties, so may the counselor do the same with the supervisor.
19. The question may arise of the relative importance of the dependency problem in the client's, counselor's and supervisor's thinking. Question of differences in point of view regarding positive and negative incentives, round-about versus direct methods — all these may contribute to the impasse.
20. Ambivalence of counselor and supervisor about terminating a case.

In making a professional adjustment the counselor in the state rehabilitation agency is confronted by three basic sociological facts of life all of which are potential factors in influencing his self-esteem and his role performance:

1. Rehabilitation counseling is an emerging profession rather than one which has completely emerged and been fully accepted. Historically it is yet too new to have been accorded a high degree of social legitimacy. It was not until 1943 when the Barden-La Follette Act (44) was passed that the counselor's role began to encompass the activities of which it is currently comprised.
2. Rehabilitation counseling is a marginal profession. Krause (22) cites medicine as the central professional reference group with other health professions such as nursing, physical therapy, occupational therapy, social work, and rehabilitation counseling occupying a marginal position in relation to it.

As a marginal profession, rehabilitation counseling has acquired some of the responsibilities, norms, values, privileges, and social sanctions of the central profession (medicine) but is denied others. For example, like the physician, the rehabilitation counselor works with disabled individuals; but unlike the physician, he receives little credit for reducing the effects of the disability. The counselor's profession is also marginal in the sense that it has not evolved a complete normative structure of its own but is governed by the norms of two different professions, medicine and education, both of which differ in their value systems.

3. In order to perform his role, the rehabilitation counselor in the state agency is highly dependent upon medical doctors, educators, psychologists, social workers, etc. Without these role partners he would be unable to perform his function.

The social status or position of the rehabilitation counselor is similar to that of a growing group of occupations which have emerged as a result of increasing technical specialization in work with people. The counselor's role derives not only from knowledge or activities that are unique to it but also from the utilization of borrowed skills and techniques and the mobilization of the contributions of other professional groups in achieving the vocational rehabilitation of the patient.

An analysis of the rehabilitation counselor's performance in the state agency illustrates this point. The determination of the prospective rehabilitee's eligibility for services is closely linked with the role of the medical profession. The medical doctor's evaluation of the client's physical capacity for successful vocational rehabilitation is of primary importance in determining eligibility. If there are questions concerning the client's physical potential, an expert medical consultant is called in by the counselor to interpret the medical findings or recommend referral to a specialist. If emotional problems are involved, the consultation of a psychiatrist is utilized. When psychometric data on the client are needed, the skills of a psychologist are brought to bear on the problem. The counselor himself collects social and vocational data about the client. On the basis of this information plus knowledge gained from other professionals, he makes a decision regarding the rehabilitation potential of the applicant.

In working out a rehabilitation plan suitable for a particular individual, the rehabilitation counselor synthesizes what he himself has learned with the information acquired by members of other professions. If physical restoration is necessary, the counselor works with the client in making the necessary arrangements. At this point rehabilitation becomes a medical procedure with services being supplied to the rehabilitee by medical doctors and members of the para-medical professions such as physical therapy, rehabilitation nursing, occupational therapy, prosthetics, etc. If a course of training is indicated following successful restoration, professional educators, either vocational or academic, assume major responsibility for the rehabilitee with the rehabilitation counselor following his client's progress. If the individual is confronted with problems during the training period, the counselor's help is always available. After the training period is completed, the counselor assumes the task of placing the handicapped person in an appropriate job. He follows his client's progress in the job setting for a period of at least thirty days. If the vocational adjustment of the rehabilitee is satisfactory, the case is closed.

From this job description it is evident that the two fundamental activities involved in the rehabilitation counselor's role are the coordination of services and the provision of a supportive relationship for the client. However, in order to perform these activities, the counselor has to depend upon a series of role partners from other professions. Without the involvement of other professional roles in the rehabilitation process, the rehabilitation counseling role in the state agency could not exist in its present form.

The symbiotic character of the rehabilitation counselor's role in no way deprecates the profession nor the high degree of skill and experience required to perform its duties well. There can be no doubt that the rehabilitation counselor is the key professional person involved in the rehabilitation of the handicapped. Yet, the facts set forth in the role analysis above should be recognized since, as will be demonstrated later, the nature and configuration of the activities involved in the counselor's role influence his self-image and his functioning in the organizational system.

Because of the recognized importance of the counselor's role in the rehabilitation of the client, much time, money, and effort have been allocated during the past ten years to develop programs and set high standards for the professional training of rehabilitation counselors. The Vocational Rehabilitation Administration has established counselor training programs on the graduate level at thirty-six universities throughout the United States at which master's degrees and doctorates in rehabilitation counseling are granted. The coordinators (directors) of these programs meet regularly and participate in seminars and projects to constantly improve curriculum, develop programs, and meet the educational needs of the counselor-in-training. Educational materials are published and made available on a national basis so that the entire field may benefit.

Such publications as the following have made valuable contributions to the literature:

> Preliminary Seminars on Curriculum Development for Rehabilitation Counselor Training Programs
>
> Guidelines for Supervised Clinical Practice
>
> Experiences of State Agencies in Hiring VRA Trainees
>
> Agency-University Communication, Coordination, and Cooperation in Rehabilitation Counselor Education
>
> A Broadening Concept of the Rehabilitation Counselor in the Total Community Rehabilitation Effort

These indicate a planful focusing of analytic concepts and a steady evolution of a sound clinical and academic program for the training of rehabilitation counselors.

Major impetus to the increase of rehabilitation counseling in status as a profession has taken place as a result of the creation of a standard-setting, self-regulatory mechanism in the form of the National Rehabilitation Counseling Association which functions as a division of the National Rehabilitation Association. The Rehabilitation Counseling Association had its beginnings as early as 1957 and is concerned with the training, certification, responsibilities, and needs of those engaged in rehabilitation counseling.

Another organization which has devoted itself to the increase of professionalization in rehabilitation counseling is the American Rehabilitation Counseling Association which is a Division of the American Personnel and Guidance Association. Its purpose is to foster the professional development of rehabilitation counselors to enable them to provide better services in the rehabilitation of the handicapped. This division is concerned with research, training, and professional standards as foundations upon which standards are based.

The Problem

If the premise that the rehabilitation counselor's attitudes and motivation influence client motivation is accepted, then it becomes important to acquire information concerning the counselor's feelings and ideas about his profession, about himself as a professional practitioner in the field of rehabilitation, and about the organizational structure within which he is employed. With the acquisition of such information as its major goal, the answers to the following questions were sought:

1. How does the rehabilitation counselor perceive his professional status?
2. What is his evaluation of his training?
3. How does he define his role?
4. What are the rehabilitation counselor's work preferences and aversions?
5. What are his attitudes toward his role partners in the rehabilitation process?
6. How does he perceive the state agency organization?

Survey of the Literature

During the past ten years much has been written concerning the role of the rehabilitation counselor: what he does, what he should do, how he should be trained, the type of personality he should have, etc. If these articles and presentations are analyzed, it becomes evident that they are based on experiences, opinions, and observations. It is only recently that some of the more formalized research techniques have been applied to acquire information concerning the components of the rehabilitation counselor's role and of his attitudes toward these components.

An important contribution in this regard was made by Jaques and Muthard (17) when they applied the critical incident technique to provide a detailed analysis of the role of the rehabilitation counselor. Their investigation indicated that:

> The creation of a therapeutic climate is of considerable importance to rehabilitation counselors in assisting the client to direct his energies toward self-help. The interpersonal relationship between client and counselor has been considered critical to client movement. To give adequate attention to this activity the counselor needs to have time to securely establish this type of counselor-client relationship.

Jaques and Muthard further suggest that:

1. More basic consideration should be given to the client-counselor relationship as a crucial function of rehabilitation counseling.
2. Emphasis might well be focused on the importance of the counselor and client working together on the client's problems. The client's needs, wishes, and interests are regarded. This approach to the client's

problems would appear to minimize ready-made and stereotyped advice given by the counselor.

3. The interpretation of professional opinion and facts appear to be especially critical in rehabilitation counseling. The skills involved in this subrole could well be a focus for increased consideration as an integral part of the whole counseling process.
4. The counselor's ability to evaluate the client in terms of his individual readiness for rehabilitation services is a critical aspect of counseling. This necessitates a concern for the unique differences of each client, moving the counseling process at the client's pace and not according to outside criteria of what constitutes progress.
5. The skills and attitudes referred to above are based on psychological knowledge and understanding of human personality and motivation. An orientation of this type should provide the framework for the training of the rehabilitation counselor.

Findings by Smits (40) in his rehabilitation counselor recruitment study indicated an average yearly turnover rate of 16.9% in 62 responding private rehabilitation agencies who employ a total of 243 counselors. The study also showed an average yearly turnover rate of 8.5% for 72 responding state rehabilitation agencies representing 2743 counselors. Both public and private agencies cited low salaries as the major reason for turnover. In the case of state agencies 58.3% were of the opinion that low salaries were the most common factor for counselors leaving their jobs. These findings of Smits concerning the comparatively low turnover of state agency counselors is of particular interest since turnover has been frequently exaggerated in estimates.

Krause (22) in his study of the Western State Rehabilitation Agency points out that there are certain structured strains which are built into the role of the rehabilitation counselor by his employing organization and by the community. He cites one strain "as a result of the legalistic definition of the counselor's role which is 'product' oriented (placement as employed) rather than humanistically oriented (the sicker they are, the more service they should get)." Such an orientation is frequently in conflict with the counselor's definition of his profession as a helping profession. Krause delineates large size of caseload, time restrictions, and pressure from the organization for quantitative output as other strains in the counselor role which influence his professional adjustment. Another highly significant strain upon the counselor is the barrier to successful placement imposed by a culture which defines illness as deviance (35). To compound this problem the nation suffers from a steady unemployment rate which affects nondisabled as well as disabled. In other words, in spite of increasing community enlightenment, the disabled individual is still, for the most part, looked at askance. His abilities and adjustment potential are regarded as suspect.

According to Krause's data, counselors in the Western State Rehabilitation Agency responded to the strains outlined above with several different adjustive or adaptive patterns. One adaptive response was aggressive behavior in the form of "cursing and complaining" against bureaucratic procedures, administrators, and referral sources. Some of this aggression is actually directed against hostile, demanding clients, slowly developing cases, uncooperative clients, etc. A second adaptive response was the lapsing of the counselor into withdrawal patterns by following the agency regulations to the letter thus escaping any emotional conflict or by persisting in behavior which is deviant from the norms of the organization. Actual physical withdrawal by leaving the agency is not infrequent. Also prevalent were symbolic patterns of adjustment; among these were idealization of the role of the counselor and rationalization of behavior.

In their article concerning opportunities in the field of rehabilitation counseling, Miller, Garrett, and Stewart (31) define the personal qualities of the rehabilitation counselor as follows:

> Physical stamina necessary to meet the demands of the position; pleasing appearance and personality necessary for personal contacts; flexibility and adaptability; capacity to recognize and deal with the problems of individuals; interest and understanding of problems of the disabled; imagination, resourcefulness, and intiative in meeting problem situations.

Rehabilitation counselors vary in their ideas as to what constitutes the best curriculum for the training of rehabilitation counselors. Dorothy Cantrell (6) reports on a nationwide survey in which 178 rehabilitation counselors were requested to rank in the order of their importance facets of the counselor-training curriculum. In the sample were 110 counselors from state rehabilitation agencies, 50 from the Veterans Administration, and 18 from private agencies. There were ten areas to be ranked; some were knowledge areas, while the others were classified as skills. The total ranks were as follows:

First — Counseling and Interviewing
Second — Professional Activities of Counseling
Third — Field Work and Supervised Practice
Fourth — Psychological and Related Areas

Fifth — Testing
Sixth — Occupational Information
Seventh — Casework
Eighth — Rehabilitation Knowledge
Ninth — Social, Community, and Related Resources
Tenth — Medical and Related Areas

However, there was substantial disagreement among state, Veterans Administration, and private agency counselors on some of the items. For example, testing was ranked eighth by state rehabilitation counselors and ninth by counselors in private agencies. Yet it was ranked first by Veterans Administration counselors. On the other hand, casework was ranked ninth by Veterans Administration counselors, while it was ranked first by state rehabilitation counselors. The greatest agreement was on the item termed interviewing and counseling.

Patterson (37) considers the counseling process itself the primary ingredient of the rehabilitation counselor's role. He is of the opinion that the counseling activities and the coordinative aspects of the rehabilitation process can be vested in the same practitioner provided counseling effectiveness is not reduced. He states that rehabilitation counseling would acquire greater professional respect if the development of basic counseling skills was the goal in training. Patterson's position is summed up in the following quote:

> If the rehabilitation agent attempts to qualify as a social worker, a public employment officer, a compensation expert, an artificial appliance expert or what not, he spreads himself so thin that his own specific function — that of counsel, advisement, supervision, and cooperation — is neglected. He becomes a jack of all trades and a master of none.

Yet not all experts on the subject share the view as expressed above. The San Francisco Chapter of the National Rehabilitation Association through its Committee on Education and Research (23) recommended the following courses for the first year of a minimum two-year program for the training of rehabilitation counselors:

Rehabilitation Counseling
Medical Survey of Rehabilitation Aspects in Illness
Psychodynamics of Personality
Sociology
Occupational Adjustment
Community Organization

Psychological Testing
Social Casework
Vocational and Occupational Counseling I and II
Legal, Financial, and Administrative Aspects of Rehabilitation
Public Assistance and Welfare Legislation

Such an academic program involves the preparation of counselors for a role considerably broader than that advocated by Patterson.

The question arises as to how broadly any university can be expected to train its rehabilitation counseling students or indeed how intensive a training sequence is possible. Peckham (38) speaks of the state rehabilitation agencies as having the "unrealistic expectation that campus training should somehow furnish the 'complete rehabilitation counselor.'"

Although the university can do much to adequately prepare students in rehabilitation counseling, the professional climate of the agency within which they become employed influences their job performance as counselors and their probability of remaining on the job. A study of 90 agencies involving 506 rehabilitation counselors which was carried out by the Joint Liaison Committee of the Council of State Directors of Vocational Rehabilitation and the Rehabilitation Counselor Educators (18) indicated that:

> . . . while those trainees who are hired by state agencies tend to stay on the job and find satisfaction in their work, increased attention to the professional climate and career aspects of the job might well increase both the number of trainees hired and their satisfaction once they are hired.

This study also showed that:

> Despite the fact that maturity and experience are highly valued in counselors, VRA counselors who are young and relatively inexperienced can be expected to receive higher ratings from their supervisors for knowledge and skill on the job than counselors who have not been trained at the graduate level.

Mary Switzer (42) sums up a rationale for rehabilitation counselor education succinctly in her statement:

> We must stress less the techniques and more the philosophy, and more the total person, operating in the environment of the total community.

> We have to do this in order to avoid fractionating the patient and we have to do it in order to avoid fractionating ourselves.

The Joint Liaison Committee of the Council of State Directors of Vocational Rehabilitation and the Rehabilitation Counselor Educators (19) stress the importance of high quality supervision in clinical practice in the development of counseling skill. This committee lists as the objectives of supervision:

> 1. To help the student experience the realities of the counselor-counselee relationship and the part that self-understanding plays in this relationship . . . and to aid the student in acquiring the ability to accept individual differences in clients.
> 2. To acquaint the student with organizational structure, protocol, relationships, processes, and working conditions.
> 3. To help the trainee recognize that the rehabilitation counselor provides an essential service not performed by other related professional persons.
> 4. To stimulate the formulation of and identification with a professional role.
> 5. To provide for an awareness of the process of community organization in meeting the needs of the client.
> 6. To provide for the seasoning of the student counselor in the realities of everyday agency or institutional experience — and an introduction to the problems of maintaining a regular counseling schedule.
> 7. To help the trainee to work co-operatively with his supervisor, fellow workers, and co-operation rehabilitation personnel . . . to gain experience in working as a member of a rehabilitation team.
> 8. To inculcate high standards of professional ethics: to give the student experience in actual interpersonal relationships which involve ethical decisions and practice (in evaluating his own motives).
> 9. To provide the student an opportunity to develop confidence in his ability to apply his professional preparation in situations which shelter him from full responsibility while providing him with opportunities for maximum professional growth.
> 10. To enable students to try out knowledges and techniques under conditions which would not be injurious to the client.

Yet, if effective supervision is to take place, efforts must be directed toward clarification of the rehabilitation counselor's role. McCauley (28) places responsibility for interpretation of the counselor's role to the agency upon the coordinators of the rehabilitation counselor training programs. He states:

> How can we expect agencies to interpret the rehabilitation counselor role always the same? This doesn't keep us as coordinators from effort at reorientation. We have a responsibility to help the agency to move into an understanding of the role or roles of the rehabilitation counselor. We need to involve administrative personnel in the curriculum of our schools. We may bring them into our school programs on advisory committees. There are two values to this: Better prospects of interpretation from both sides, which promotes common understanding, goals, and training.

In another paper, Usdane (43) points out some of the difficulties which confront the emerging profession of rehabilitation counseling in his statement that:

> The rehabilitation counselor is faced with little written information in the field concerning the actual techniques of counseling with the disabled. Plentiful are generic counseling texts and within the past few years, there has been increasing literature on theory and practice, specialized demonstration projects, and the role and function of the rehabilitation counselor. But little has been concerned with some of the specialized techniques themselves.

Nevertheless, he demonstrates that the profession of rehabilitation counseling is resolving its problems and making progress in the process of organizing its techniques into an internally consistent system or body of theory.

Magoon (25) documents constructive progress in the field of rehabilitation counseling by pointing up innovations in counseling (the use of audio-visual media, etc.) and asserts that "innovations in any field are symptomatic of a dynamic self-criticism and search for improvement through change."

In summary it can be said that the literature on the role of the rehabilitation counselor reflects a profession which is in a state of flux and which is striving to define its activities and delineate its boundaries. The past ten years has been a period of progress in the rehabilitation counseling profession which has been marked by searching inquiry into the role of the counselor and continuing evaluation and improvement of his graduate curriculum.

Method

The first phase of the project took the form of an exploratory study of counselor attitudes by the Research Director. On the basis of informal conversations with counselors during which various attitudes were elicited a questionnaire (see Appendix A) was designed. Lists of names and home addresses of rehabilitation counselors were obtained from the state rehabilitation directors of the New England states. Questionnaires with a cover letter (see Appendix B1) were then sent to all the counselors in the New England state rehabilitation agencies. A total of 137 counselors received the questionnaire. One hundred questionnaires were completed and returned as a result of the first mailing. Three weeks after the initial mailing, a second mailing with a different cover letter (see Appendix B2) went out to all counselors. An additional fourteen questionnaires were received, bringing the return rate to 85.0%. Most responses were precoded and readily lent themselves to IBM tabulation. Data was analyzed by cross-tabulation and significance established using the chi square test. To be accepted as significant, a chi square value had to have a probability less than 5.0%.

Another rich source of data were the unstructured comments contributed by the respondents. A page was left blank on the questionnaire on which counselors were invited to write any comments they might want to make either about the study or on any of the substantive areas contained in the questionnaire. Most of the counselors responding did include comments. These varied in length from one or two sentences to a page and in some cases even more. In most cases, comments indicated that the responding counselors related very well to the purpose of the study and were genuinely interested in cooperating. Comment on the questionnaire was generally favorable although there were three counselors who expressed open hostility to it. Many were highly enthusiastic about the study, felt that it was very much needed, and wished it well. For the most part, counselors made some criticisms of their agencies in this section. These criticisms were not written in a hostile way but were in the nature of complaints in which factors impeding their effectiveness as rehabilitation counselors were discussed.

From material included in the comments section, it was apparent that the responding counselors completed the questionnaires with a great deal of thoughtfulness. The questionnaire was designed so that it could be completed in twenty to thirty minutes; nevertheless, some counselors indicated in later informal discussions with the researcher that it took them from one to one and one-half hours to complete it because they had to do much thinking to answer the questions as objectively and candidly as they could. There are always limitations with respect to reliability inherent in data gathered by mailing out questionnaires. In view of the expressed interest of the respondents and the specialized nature of the data, it is felt that reliability and validity problems were somewhat reduced.

It must be emphasized here that the findings of this study apply to New England state rehabilitation counselors only and cannot be extrapolated to describe counselors in other parts of the country.

Nevertheless, other regions are also greatly concerned with the study of the profession of rehabilitation counseling. The Regional Rehabilitation Research Institute at the University of Wisconsin has as its core research area the role and function of the rehabilitation counselor. The University of Utah's Regional Rehabilitation Research Institute is carrying out research on the rehabilitation counselor's interpersonal relationships with clients in rural areas.

The results of research at these two research institutes will undoubtedly shed light upon some of the complex problems which confront the rehabilitation counselor.

THE REHABILITATION COUNSELOR
VIEWS HIS ROLE

The counselor in the state vocational rehabilitation agency views his role in one of two ways. Either he perceives himself as a coordinator of services and is highly oriented to vocational placement of the handicapped individual, or his major interest is in dealing with the social and emotional adjustment of his client. In the latter role concept, placement then becomes only one factor in the total personality adjustment of the client.

The role orientation of the counselor is of crucial importance since it can influence his morale and his productivity both qualitatively and quantitatively. The legalistic reality and organizational purpose of the state rehabilitation agency at this time require that a placement orientation be adopted. The emphasis on vocational placement by the state-federal rehabilitation program stems not from a philosophy which demands placement for placement's sake but rather from a philosophy which regards remunerative employment of the handicapped individual in itself as psychotherapeutic and facilitating adjustment.

Whether or not these two differing role perceptions can be reconciled within the same agency or indeed within the same counselor is a matter for further study. It is hoped that the findings set forth in this study will highlight the problem and suggest avenues along which to seek its solution.

The role of the state vocational rehabilitation counselor is one of the most complex in the entire spectrum of professional roles. The counselor participates in many varied activities and must enter into and negotiate within many varied social subsystems. At one moment he must relate to the world of medicine. Next he is a part of the educational subsystem. Shortly thereafter he must relate to the intricacies and vagaries of the employment market. It would appear that the coordinative and environmental manipulative functions of his role are paramount. Yet data gathered in this study indicate that many counselors tended to view their role as psychotherapeutic. The findings show that 83.0% of the counselors responding expressed the opinion that psychotherapy was a component of rehabilitation, while 69.2% frankly admitted that they felt rehabilitation counseling was a form of psychotherapy. The interest of the vocational rehabilitation counselors in the psychodynamic aspects of counseling was expressed by one counselor in the following statements:

> I feel strongly that the state agencies must work more and more with the severely handicapped whose problems are beyond the point of being helped by other agencies.
>
> Counseling is the core of any rehabilitation program. A well-developed philosophy of disability and of the counselor's role is essential.
>
> We must become more acutely aware of the emotional and psychological aspects of disability — not only because of the increasing caseload of emotionally disturbed clients, but because awareness is so essential to the handling of problems of clients with physical disabilities.

There are other indications that rehabilitation counselors in the state agencies have a strong interest in a psychotherapeutically oriented type of counseling. When counselors were asked what treatment plan they would adopt if a client was experiencing problems in his family relationships which were blocking rehabilitation, 44.8% indicated that they felt it would be best if they could treat the problems themselves rather than refer the client to a family service agency or a psychiatrist.

What is important to recognize is that the desire of the rehabilitation counselor to carry on psychotherapy is no fleeting whim but a consistent and rather constant goal. As is indicated by the data presented in Table 1, rehabilitation counselors who prefer to treat their client's family problems also select mental illness as the disability which they most prefer to rehabilitate.

TABLE 1

Relationship Between Preference for Working with Mental Illness and Method of Management of Family Problems

	Refer family problems to social worker	*Counsel family problems themselves with psychiatric consultation*	*Total*
Prefer to work with mental illness	5	7	12
Other work preferences	36	9	45
Total	41	16	57

Chi Square = 6.89, df 1, $p < .01$

Thus it would seem that those counselors who are interested in acting as psychotherapists will more frequently seek out opportunities to do so from within their rehabilitation caseload. Not all counselors selected mental illness as the disability with which they preferred to work. However, 20.2% indicated this preference. This is an interesting finding since counselors are frequently accused of not wanting to rehabilitate mentally ill patients because they feel uncomfortable with them. Moreover, mental patients are generally difficult to place in employment as a result of adverse community attitudes. As shown in Table 2, almost as many counselors (20.2%) prefer to work with mentally ill clients as prefer to work with amputees.

TABLE 2

Counselor Case Preferences

Disability	*Per Cent*
Neurological Motor Impairments	7.1
Amputees	25.0
Visual	21.4
Speech and Hearing	3.6
Mental Illness	20.2
Mental Retardation	7.1
Incapacity Diseases	15.5
Intercurrent Acute Episode Diseases (e.g., epilepsy, etc.)	—

N = 84 (77.1%)

When questioned concerning cases which they least preferred to work with, counselors responded as indicated in Table 3.

It would seem that predictability of client behavior is an important consideration in the counselor work preferences. Mental illness, mental retardation, and intercurrent episodic diseases such as epilepsy all have unpredictability as a variable and are least preferred by the greatest number of counselors. There is little question that unpredictable client

TABLE 3

Cases Least Preferred by Counselors

Disability	*Per Cent*
Neurological Motor Impairments	3.7
Amputees	2.4
Visual	4.9
Speech and Hearing	11.0
Mental Illness	25.6
Mental Retardation	25.6
Incapacity Diseases	4.9
Intercurrent Acute Episode Diseases (e.g., epilepsy, etc.)	22.0

N = 74 (67.9%)

behavior not only poses a difficult problem in counseling but also affects success rate in rehabilitation. This may explain the lower preference for illness primarily mental in character in contrast to those primarily physical in character. This inference is supported by the responses of counselors concerning their reasons for preferring and not preferring to work in the rehabilitation of particular types of pathology. As noted in Tables 4 and 5, 38.0% of the counselors responding preferred to work with cases because of the speed and ease of success of the case in vocational rehabilitation, while 55.0% (over half) of the counselors preferred not to work with particular cases because of lack of speed and ease of success in rehabilitation and placement.

These data concerning the work preferences of the rehabilitation counselor point up major gaps in counselor motivation to work with particular kinds of disability. The fact that only 3.6% of the counselors preferred to rehabilitate speech and hearing cases can be considered cause for some concern since communication defect is one of the most disabling and frustrating of handicaps to the patient not only physically but emotionally as well. Although the data show that

TABLE 4

Counselor Reasons for Preferring to Rehabilitate Particular Types of Disability

Reason	*Per Cent*
Experience with and knowledge of disability	24.7
Speed and ease of success in achieving vocational rehabilitation	38.3
Combination of speed and ease of success and counselor's experience and knowledge	6.2
Stimulating challenge to the counselor	19.8
Interest in the particular disability because of personal reasons	3.7
No particular preference	3.7
Other reasons	3.7

N = 81 (74.3%)

21.4% of the counselors prefer to work with visual handicaps, most of these are counselors who work exclusively with the blind and who, for various reasons, have elected to concentrate their efforts and skills in this area. Thus the findings of this study raise the question of whether or not the rehabilitation of clients with speech and hearing disabilities is a sufficiently specialized area to warrant the training of specialist counselors to work exclusively in the area of communication defects in much the same manner as the counselors who rehabilitate the blind.

Perhaps the major problem which these counselor preference findings alerts us to is this: How does the preference of the counselor to work with a particular type of disability affect or influence his selection of cases in the process of determining eligibility? Does he select for service essentially the types of cases with which he is most familiar and which promise speed and success in vocational rehabilitation? If he does, then not only is the distribution of the cases accepted for rehabilitation services skewed in a given direction, but the counselor short-changes himself in terms of gaining experience with a broad range of cases and limits the buildup of his skill as a rehabilitation counselor. Since logic supports a cautious inference that the process of determining eligibility is influenced by counselor disability preferences, the problem is certainly ripe for research.

TABLE 5

Counselor Reasons for Not Preferring to
Rehabilitate Particular Types of Disability

Reason	*Per Cent*
Little experience with and knowledge of disability	10.8
Lack of speed and ease of success in achieving vocational rehabilitation	55.4
Combination of lack of speed and ease of success and counselor's particular experience and knowledge	2.7
Lack of community resources to facilitate rehabilitation	9.5
Communication problems with client	5.4
No preferences	2.7
Other reasons	13.5

N = 74 (67.9%)

The counselor must be able to evaluate severity of handicap relative to various vocational requirements: assess the client's intellectual and emotional function in terms of motivational factors, understand the social components of the client's family and community life, and synthesize these variables into a meaningful configuration known as rehabilitation potential. If disability preferences are a source of bias, the counselor will be unable to carry out objectively this process in determining eligibility.

Attempts to learn something about the counselors who preferred to work with particular types of handicap were not successful since most tests of association proved not to be significant at the .05 level.

However, one significant finding was obtained. Counselors who preferred to rehabilitate mentally ill patients were newer to the rehabilitation counseling profession than counselors who did not have this preference (see Table 6).

TABLE 6

Relationship Between Preference for Working with Mental Illness and Length of Time in Field of Rehabilitation

	Years		
	1 - 3	*4 - 10*	*Total*
Prefer to work with mental illness	11	3	14
Other work preferences	17	25	42
Total	28	28	56

Chi Square = 4.67, df 1, $p < .05$

This finding is understandable in the light of the recency of training of the newer counselors. Most of them are younger and since they have come from rehabilitation counselor-training programs or have taken courses in education, they have been exposed to instruction regarding modern treatment methods of mental illness and the psychology of adjustment. The older counselors became part of the profession at a time when the goal of vocational placement for the handicapped person was paramount. All rehabilitation was thought of in terms of return to remunerative employment. This philosophy considers work as the principal therapy for the disabled. The newer counselors, on the other hand, regard the psychotherapeutic aspects as being of primary importance in the rehabilitation of the handicapped individual. They view these aspects of rehabilitation counseling as the most challenging, the most professional, and the most prestigeful. Thus the rehabilitation of the mentally ill, in which the total disability is of a psychosocial nature, appeals to them.

While it is true that rehabilitation counselors in the state agency show a certain homogeneity in regard to their general organizational purpose, their attitudes relative to the methods of achieving this purpose are quite heterogeneous. The following statements made by counselors who contributed data for this study illustrate this point:

> I feel that very strong accent should be placed on the vocational aspects of our program. I have found that doctors, social workers, teachers, and psychologists have very limited knowledge of the labor market and its jobs. As vocational rehabilitation counselors, we should be able to spend much more time in employer visiting and other labor market activities.
>
> It appears to me that our system tends to increase the dependency of the client. I think we would do well to copy the system used by the United States Employment Service which in my opinion has the best and fastest technique of any government agency. By placing the burden of maintaining contact upon the client, his initiative is increased, not destroyed. I feel that unless the counselor is delegated more authority, the problems involving surgery and hospitalization can best be handled by some other agency.

In the quotation directly above the respondent perceives the role of the rehabilitation counselor in the state agency in highly practical terms. His approach is direct and directive and his conceptualization of the rehabilitation process is completely within the vocational frame of reference. The view of the vocational rehabilitation counselor role described in the quotation below is much broader and is more concerned with the personality adjustment of the client:

> I think three phases of our work are most important: (1) knowledge of community health, education, and welfare agencies; (2) knowledge of job occupations from professional to unskilled; (3) ability to work with disabled individuals and treat their psychological problems.
>
> Numbers one and two can be learned, but number three is my pet criticism of rehabilitation personnel. I feel that somewhere in the graduate program a committee of faculty members must judge the qualifications of a rehabilitation counseling student's ability to work with disabled people. Certainly not all who receive their Master's degree in vocational rehabilitation are qualified to deal with them from what I've seen. I think the counselor must be able to put himself in each client's position. He must be completely unbiased toward the client's race, color, religion, morality, attitude, disability, education, intellect, etc. With bias in any one of these, a counselor is simply not able to function.

Perhaps there are some who would accuse this counselor of overidentification with his handicapped clients and would state that his attitudes would foster dependency and be detrimental to progress in rehabilitation. This may or may not be the case; yet his statement does indicate a concern for the client's personality structure and for his need to have the acceptance of the counselor. Such a view is quite different from that expressed by the previous respondent.

The manner in which a professional perceives his role depends to a great extent upon the nature of the goal or the end product of that role. This is particularly so in the case of the vocational rehabilitation counselor in the state agency. By definition, the goal of the state agency is the successful vocational placement of the disabled client in remunerative employment. This is a discernible end product which can be observed, counted, evaluated, and used as a measure of counselor performance, at least in a quantitative way. The counselor considers himself a success or failure with a particular client on the basis of whether or not he has been able to successfully place him in employment. Vocational rehabilitation counseling is one of the few fields in which success and failure are so clear cut. In fields such as psychiatry, social welfare, family counseling, etc., there is no end product which is clearly discernible. Whether or not and how much the client has been helped by these professions is usually determined by the individual practitioner himself. Statistically, his quantitative productivity is judged not by the number of improved clients but rather by the number of clients he is working with at any given time. In other words, his success is not so readily observable or apparent. In the case of vocational rehabilitation, however, the highly discernible end product (the status 12 or successfully placed case) can place some counselors under tension and anxiety over productivity.

One finding leads to some interesting questions concerning productivity factors in the role of the state vocational rehabilitation counselor. Table 7 indicates the distribution of the counselors' responses concerning use of their time. If the upper three levels of Table 7 are combined, 84.4% of the rehabilitation counselors responding thought that 20.0% or less of the counselor's total time should be spent on cases which have a doubtful prognosis for vocational rehabilitation. Yet in the question immediately preceding the one above on the questionnaire, more than three-fourths of the counselors (76.2%) stated that they thought the rehabilitation of the severely disabled and chronically ill for independent living (to care for their own daily living needs) as important as vocational rehabilitation.

How can these two responses be reconciled? It would appear that in facing the reality of an organizational purpose which is end-product oriented, the counselor does not want to risk any substantial decrease in quantitative productivity by working on too many cases with a

TABLE 7

Counselor Opinion Concerning Amount of Time Which Should Be Devoted to Serious Disability with Doubtful Prognosis for Vocational Rehabilitation

Per cent total counseling time advocated	*Per cent counselor response*
Less than 10	41.7
10	21.9
20	20.8
30	6.3
40	—
50	7.3
More than 50	2.1

N = 96 (88.1%)

doubtful prognosis. However, the reality oriented approach which he makes toward the goals of his employing organization does not prevent him from having conflicting value orientations which may have much meaning to him but which he is unable to act upon. He may be emotionally committed to a definition of rehabilitation which includes helping the disabled to live at a higher level without becoming gainfully employed. Nevertheless, he must adjust to working within an organizational system in which rehabilitation is defined within a legalistic framework and which has as one of its attributes end-product orientation. However, in others this value conflict can be detrimental to their performance both qualitatively and quantitatively. Some counselors are able to adapt to the definition of the situation.

The analysis set forth above in no way impugns the vocational emphasis of rehabilitation as it is defined under the state-federal program. As a matter of fact, the end-product orientation of the state agency programs has the advantage of insuring that the amount of rehabilitation services available will be judiciously used in order to help those disabled individuals who will receive the greatest benefit from them. However, what is important is that this study indicates that what the rehabilitation counselor does and what he thinks are not necessarily in harmony; that is, his actions and his values may well be in opposition to each other. The implications here are that while some counselors are able to resolve this conflict with relative ease, the potential for staff discontent and morale problems is always present. Therefore, it behooves rehabilitation supervisors and administrators to be aware of potential problems in this area and to be watchful for counselors who are having difficulty in the resolution of this conflict. If these counselors can be identified, then supervisors will be in a position to help. Not infrequently this can be accomplished by discussions, adjustment of the counselor's caseload to better meet his professional needs, etc.

Summary

In this chapter responses of vocational rehabilitation counselors indicate differences in the perception of their own counseling role. There are apparently two points of view among counselors. One characterizes the counselor as an intermediary between the disabled client and the so-called normal community. In this role he functions as a manipulator of the environment. He mobilizes the community's resources in the client's behalf and is particularly concerned with securing or helping the client to secure remunerative employment. The second characterizes the counselor as a type of psychotherapist or psychological counselor. In this role the interpersonal transactions in the counselor-client relationship are considered of greater importance than the environmental manipulative function. Naturally, these role perceptions do not exist in a pure state in most counselors. The findings of this study do point to the fact that counselors hold views that lean more strongly toward one or the other dimension.

The data in this chapter also show that counselors have very definite preferences concerning the type of disability with which they desire to work. These findings are of importance because they show that in terms of counselor interest certain types of disability are rather badly neglected. It is postulated that such preferences influence the selection of cases in the process of determining eligibility. Moreover, counselors who work with less-preferred types of disability may themselves be less motivated and in turn be less able to motivate their clients.

THE REHABILITATION COUNSELOR VIEWS HIS TRAINING

It can be stated that professional training influences professional role. This is more of a truism than a hypothesis. A large part of what a professional rehabilitation counselor develops in the way of effective counseling skill and commitment to the profession depends to a great degree upon the nature and extent of his training. At present, curriculum patterns for the training of vocational rehabilitation counselors in university settings are in a state of flux. Curriculum content and substantive emphasis differ among universities. In some quarters cries for standardization have arisen. In others the need for further creative experimentation has been stressed. Certainly there is no pat or simple solution to the problem. What is clear, however, is that there is much to be learned if counselor-training programs are to meet the needs of the professional rehabilitation counselor.

Almost two-thirds of the counselors (66.0%) stated that they were not satisfied with their professional training as rehabilitation counselors. Table 8 shows the distribution of the principal reasons sup-

TABLE 8

Counselor Reasons for Dissatisfaction with His Professional Training

Reason	*Per Cent*
Too little or no training	21.0
Training too theoretical (not realistic)	22.6
Lack of information concerning occupations and labor market	17.7
Too much emphasis on psychological principles and psychometrics	4.8
Lack of material on motivation and the dynamics of personality functioning	4.8
Lack of sufficient practicum (field work)	8.1
Other	21.0

N = 62 (56.9%)

plied by counselors to explain their dissatisfaction with the formal educational preparation for assuming the role of the vocational rehabilitation counselor in the state rehabilitation agency. As the distribution indicates, there is no single reason for counselor dissatisfaction with training. While the breakdown does not produce an even distribution, the spread is broad. Perhaps the major value of these descriptive data is that they highlight the fact that over one-fifth (21.0%) of the counselors who were dissatisfied with their training felt inadequately trained in the sense that they had too little training. Nearly one-third (30.7%) felt that their training was too theoretical and lacked sufficient practicum. Such feelings of inadequacy in the area of professional training can cause deficiencies in counselor motivation, depreciation of professional self-image, and feelings of professional inferiority when negotiating and relating to members of other professions.

The data make it quite evident that most rehabilitation counselors in the state agency feel the need for advanced training beyond the undergraduate level. Table 9 describes the opinions of rehabilitation

TABLE 9

Counselor Opinion Concerning the Ideal Structure for a Training Program in Rehabilitation Counseling

Type of Program	*Per Cent*
Four-year course leading to the Bachelor's degree	14.0
One-year Master's degree	26.2
Two-year Master's degree with field work	46.7
Four-year course leading to the Doctorate	2.8
No college degree but knowledge acquired through on-the-job training and experience	10.3

N = 107 (98.1%)

counselors concerning the degree of training which they advocate for the field of rehabilitation counseling. It should be noted that 75.7% of the rehabilitation counselors who responded felt that the course of training for rehabilitation counselors should be at the graduate level and should culminate with the award of an advanced degree. Only 14.0% of the counselors felt that a Bachelor's degree was sufficient to optimally prepare the counselor to assume his role in the state rehabilitation agency.

The thirst for the knowledge and prestige of advanced degrees which is felt by some rehabilitation counselors is summed up in the following quotation:

> At least a two-year graduate program is acceptable; however, a four-year course with a Ph.D. would be preferable. So much of the counseling graduate level courses are theoretical. There is a need for practical experience to prepare counselors for practical work as well as there is a need for theory. The actual problems encountered in practice were never put in textbooks or classroom theoretical situations. The teachers of these courses should be specialists in the field . . . Educators have their own little "ivory towers." We should gear our school programs to meet the increasing possibilities of rehabilitation by using experienced counselors to teach what they already know and put out graduates fully qualified to do the job needed.

The pertinent question then is what subject matter should be included in the curriculum of the rehabilitation counselor which will result in his becoming a qualified counselor. There is no simple answer. However, the assumption can be made that practicing rehabilitation counselors in the state agency will have some knowledge (based on their own personal experiences) concerning what they were taught or should have been taught to perform their professional role effectively. Accordingly counselors were asked to rank in the order of importance the subject areas which should be emphasized in the professional training of the rehabilitation counselor. Table 10 contains the results of this ranking procedure.

The counselor's evaluation of the relative importance of areas to be taught in rehabilitation counseling curricula is consistent with the counselor's definition of his role. As indicated by Table 10, the major proportion of the counselors rank knowledge of psychology of personality functioning first (48.6%) and vocational information and employment potential second (34.9%). This finding is congruent with the counselor's perception of his role as either primarily placement agent or psychotherapist.

TABLE 10

Counselor Ranking of the Importance of Subject Areas as Part of the Professional Rehabilitation Counselor-Training Curriculum

	Per Cent of Counselors for Each Rank				
	1	2	3	4	5
Psychology of personality functioning	48.6	22.0	15.6	8.3	5.5
Knowledge of vocations and employment potential	34.9	27.5	25.7	10.1	1.8
Community organization techniques	——	7.3	12.8	27.5	52.3
Medical knowledge of disability	16.5	30.3	31.2	16.5	5.5
Psychological testing	——	12.8	14.7	37.6	34.9

N = 109 (100%)

Counselors who are satisfied with their professional training believe that rehabilitation counseling is a form of psychotherapy. Table 11 demonstrates this. One explanation for this might be that the increase in psychological content in the graduate rehabilitation counseling curricula finds favor among those counselors who view rehabilitation counseling as a psychotherapeutic endeavor. The counselor who perceives himself as functioning in the role of a psychotherapist feels his

TABLE 11

Relationship Between Satisfaction with Professional Training and Belief That Rehabilitation is a Form of Psychotherapy

	Yes	No	Total
Satisfied with professional training	68	19	87
Not satisfied with professional training	4	14	18
Total	72	33	105

Chi Square = 19.14, df 1, $p < .001$

activities are more prestigeful, and thus his morale level is raised. Such a counselor would be more satisfied with all aspects of rehabilitation counseling including training. Actually both of the conditions outlined above might be operative.

Another area of investigation dealt with by this study was counselor attitudes toward their in-service training. Since all rehabilitation counselors in the state agencies have not had the advantage of formalized university training, the effectiveness of in-service training is of primary importance. Of the counselors studied, 90.8% had in-service training. Of the counselors who did have in-service training, 86.1% indicated satisfaction with it. The remaining 13.9% stated the following reasons for their dissatisfaction:

1. The training was too theoretical and not geared to reality.
2. No material was presented with which they were not already familiar.
3. The amount of in-service training was not of sufficient quantity to be of real value.

In order to gain some insight into the rehabilitation counselor's image of his own training in comparison to other similar counseling or helping professions, he was asked to select from the professions of social work, school guidance counseling, and rehabilitation counseling the one whose graduate training curriculum best fitted the practitioner for his professional role. More than half of the counselors (51.4%) felt that the professional social worker's curriculum best fitted him for his role. Rehabilitation counseling was selected by only 29.0%, and school guidance counseling was chosen by 19.1% of the responding rehabilitation counselors. Again these findings are consistent with the role perception of the rehabilitation counselor as described by this study. In the graduate training of the social worker, psychodynamics and personality theory are highly stressed; and the psychotherapeutic aspects of the role are, if not openly, tacitly implied. Thus the rehabilitation counselor admires the professional training which stresses the dynamics of behavior and which prepares the practitioner to occupy a psychotherapeutic role.

The rehabilitation counselor's respect for the psychotherapeutic role and his aspirations to it again come to the fore in his selection of the social worker as being better trained for his role than the guidance counselor. The guidance counselor has traditionally been trained with an emphasis on psychometrics and conscious mental processes, while the social worker has been trained with an emphasis on the understanding and treatment of clients based on a knowledge of depth psychology (see Table 12).

TABLE 12

Relationship Between Belief that Rehabilitation is a Form of Psychotherapy and Professionals Which are Best Trained for Their Role

	Believe Social Worker Best Trained	*Believe School Guidance Counselor Best Trained*	*Total*
Believe rehabilitation is a form of psychotherapy	41	11	52
Believe rehabilitation is not a form of psychotherapy	11	9	20
Total	52	20	72

Chi Square = 4.09, df 1, $p < .05$

The implications of the data in this chapter are quite clear. The rehabilitation counselors in the state agencies view their training needs in much the same way as they view their role — with differing emphasis. Some feel that they should be trained to place clients vocationally; others, in addition to vocational placement, feel that they should be trained to treat the psychosocial problems which develop as a result of the handicap.

One of the major goals of any professional training program is providing the student with a clear understanding of his professional role. The data suggest that training programs are having some difficulty in achieving this goal. Perhaps the difficulty stems from the fact that the role of the rehabilitation counselor in the state agency has not been well defined in practice and differs somewhat from agency to agency.

However, what can and must be inculcated in the training of all rehabilitation counselors is the unified concept of the counseling role. The role cannot be successfully taught if it is taught as a fragmented group of activities. The counselor should be helped by his training to acquire a philosophy of rehabilitation counseling which does not separate treatment from placement, but which regards vocational placement of the handicapped person as an important part of treatment. The psychodynamic interaction between counselor and client (process of treatment) then becomes the vehicle by which placement is facilitated and achieved. The teaching of such a role concept is well within the realm of possibility and when planfully pursued can be achieved without great difficulty.

Of much greater difficulty is the planning of an in-service training program which will have the maximum effect in meeting the diversified educational needs of rehabilitation counseling staff. A rapid perusal of Tables 1 through 6 (see Appendix C) demonstrates the heterogeneity of background of the counselors. If material presented in in-service training programs is of a theoretical nature, it will frequently be rejected by the veteran counselor as impractical and "ivory tower" in nature. Yet, the veteran counselor is often one whose formal training in rehabilitation counseling is sparse and to whom some theoretical knowledge would be of much value if it could be accepted and integrated by him. On the other hand, the newer and more formally trained counselor who would benefit from a more practical orientation seeks training of a more theoretical nature. He sees this type of knowledge as having more status and at times uses it as a support for his resistance to functioning in a more practical and down-to-earth manner when the situation demands it.

The solution may lie in stratifying the in-service training program so that to some extent counselors are grouped according to experience and training. Grouping has the disadvantage of eliminating the valuable exchange of knowledge which takes place among individuals with differing ideas and information. On the other hand, under a grouping system, training needs of counselors can be more easily identified. Thus counselors in an in-service training program could be provided with some of the training which they want and much of the training they need. For small state vocational rehabilitation agencies such stratification for in-service training is impossible. Nevertheless, even in small agencies training sessions are most effective when the educational and experiential backgrounds of the counselors are carefully considered. In short, an in-service training program must be based upon a diagnosis of the counselor's training needs and performance potential in much the same way as a rehabilitation plan is based on the needs of the handicapped client and his rehabilitation potential.

Judging from counselor responses and comments, an in-service training program should supply the material which will assist in developing the following skills and knowledge:

1. The ability to help the client to select and make the best vocational placement. This means not only placing the client in a job but rather placing him at the highest level of his capacity and vocational potential without subjecting him to undue physical, social, or emotional stress.
2. The ability to utilize community resources judiciously for the benefit of the client. Knowledge of the appropriate use of community resources is for the most part developed through actual experience. However, skill in interagency negotiations, involving the case conference method, exchange of written communication, etc., can be discussed during in-service training in a manner which is helpful to the actual process when it takes place.
3. Knowledge of the psychodynamic principles involved in the rehabilitation counseling process. The in-service training program is uniquely well suited to teach psychological principles as they apply to the handicapped individual. Moreover, it provides counselors with the opportunity for a seminar-type discussion of the dynamics in cases with which they work.
4. Skill in case recording, office procedures, and other mechanical aspects of the job. Counselors pointed out that one of their major problems was finding the time to make adequate records, deal with service accounting problems, etc. Such mechanical procedures can cause a counselor to become bogged down and such a situation can have a depressing effect upon his motivation. The in-service training program can be utilized to teach brief and efficient methods for dealing with these problems.

Summary

Two-thirds of the rehabilitation counselors who responded felt generally dissatisfied with their training for the professional role which they occupy. Their major reason for this feeling was lack of sufficient training both quantitative and qualitative. This attitude is of importance since it can produce feelings of professional inadequacy which can result in poor motivation and a consequent inability to motivate the client. Because of the heterogeneous backgrounds of the rehabilitation counselors in the state agencies, training needs among them differ. This produces a difficult problem in planning in-service training programs. A diagnostic approach to the problem of rehabilitation counselor training is necessary.

THE REHABILITATION COUNSELOR'S RELATIONSHIP TO HIS PROFESSION

Members of a profession usually form a relationship to that profession. While this relationship may not be a personalized one, the profession does in a sense take on an identity to which its members relate. For example, the practitioner may feel acceptance or hostility for the profession. The practitioner may feel secure or insecure within it. He may regard the profession as prestigeful or lacking prestige. In other words, the professional develops affect regarding his profession which in part determines how he relates to it. The relationship of the rehabilitation counselor to his profession is of primary importance since his morale and performance are factors which affect the motivation and subsequent success of the client in becoming rehabilitated. Moreover, the counselor's commitment to a philosophy of rehabilitation will be influenced by his attitudes toward the profession of rehabilitation counseling. His motivation to help the handicapped client will be either amplified or attenuated by his professional value orientations. The feelings and attitudes of the rehabilitation counselor toward the state rehabilitation agency will also be influenced by his relationship to the profession.

One of the purposes of this part of the study was to investigate how rehabilitation counselors felt about their membership in the profession and to gain some understanding as to their professional self-image. Specifically, the manner in which the rehabilitation counselor in the state agency defines his profession and his evaluation of how well his occupation meets such professional criteria were studied.

The definition which, in the author's judgment, comes closest to describing the rehabilitation counselor's conception of a profession is that suggested by Greenwood (11). He views a profession as having the following attributes:

A systematic body of theory
Professional authority
Sanction of the community
A regulative code of ethics
A professional culture

All professions possess these attributes, but it is the degree to which they are possessed that determines the degree of professionalism and public prestige accorded a profession.

The data suggest that counselors feel that all five attributes are not present to a high degree in the profession of vocational rehabilitation counseling. Rehabilitation counseling has the sanction of the community and a segment of this community sanction is legally legitimated. In addition, rehabilitation counseling is developing its own professional culture. However, in the case of the other three attributes, counselors feel that it falls short.

1. Rehabilitation counseling is in a stage of theoretical infancy. It is only making the barest beginnings in attempting to evolve a systematic body of theory. It has thus far borrowed the greater part of its theoretical concepts from medicine, psychology, and education.
2. Only recently has there been concern within its professional associations for the development of a regulative code of ethics.
3. Its professional authority, while having weight with its clientele, has questionable weight with the members of other professions. At this point in its development, the profession of rehabilitation counseling must rely on the venerated authority of the medical profession.

This analysis is in no way meant to minimize the importance of or depreciate the profession of rehabilitation counseling. It is rather to highlight the problems of a new profession and to introduce the following finding which, in the opinion of the writer, should be cause for concern within the field of vocational rehabilitation. Of the 107 (98.2%) counselors who responded to the question almost half (43.9%) stated that they would rather be in a profession other than rehabilitation counseling. Of those counselors, 75.0% would actually

TABLE 13

Relationship Between Counselor Preference to be in Another Profession and His Intention to Leave if He Were Financially Able

	Would prefer to be in another profession		
	Yes	No	Total
Would leave rehabilitation counseling profession	31	11	42
Would not leave rehabilitation counseling profession	14	48	62
Total	45	59	104

Chi Square = 26.77, df 1, $p < .001$

leave rehabilitation counseling if they were financially able to train for another profession. This finding can be considered highly significant as is indicated by Table 13.

Table 14 shows the distribution of counselor response to the question of what profession they would rather be in than rehabilitation counseling. Although some of the counselors failed to indicate or did not know what profession they would prefer, the small number who did state their preference suggests a discernible trend. The majority would like to be either in medicine or psychology. These are professions which enjoy high public prestige and, what is more, carry the weight of a great deal of professional authority.

TABLE 14

Counselor Preferences of Professions
Other Than Rehabilitation Counseling

Profession	*Per Cent*
Medicine	32.6
Psychology	23.9
Guidance and counseling	3.7
Teaching	5.5
Other related professions	3.7
Other nonrelated professions	5.5

N = 46 (42.2%)

The self-image which a professional has can profoundly influence his relationship to that profession and his desire to remain in it or leave it. Most professionals carry their own perception of the public prestige which their profession enjoys. The accuracy of this perception can be questioned since studies have shown that the professional's perception of his public prestige frequently differs from what it actually is.

In an attempt to learn how rehabilitation counselors feel about their own public image, respondents in this study were requested to rank eight professions. The professions which they were requested to rank were in many ways similar to rehabilitation counseling in that they were salaried, not top-prestige professions (e.g., medicine, law, etc.), and with the exception of teaching had some relationship to the medical profession. Table 15 shows the counselor ranking of the eight professions. The fact that such a large percentage (91.7%) of the counselors answered this question completely indicates their interest in the problem of professional prestige.

TABLE 15

Counselor Ranking of the Eight Professions in Prestige

	Per Cent of Counselors for Each Rank							
	1	2	3	4	5	6	7	8
Nurse	33.7	26.7	12.9	7.9	3.7	6.9	3.0	5.0
Teacher	40.6	28.7	5.9	9.9	5.9	4.0	2.0	3.0
Rehabilitation Counselor (public)	4.0	13.0	23.0	16.0	21.0	5.0	10.0	8.0
Psychiatric Social Worker	14.0	10.0	21.0	9.0	12.0	11.0	9.0	14.0
Other Social Workers	—	5.9	9.9	14.9	13.9	19.8	15.8	19.8
Rehabilitation Counselor (private)	5.1	8.1	9.1	24.2	19.2	14.1	9.1	11.1
Physical Therapist	3.0	6.9	14.9	5.0	19.8	17.8	25.7	6.9
Occupational Therapist	1.0	1.0	3.0	13.0	4.0	21.0	25.0	32.0

N = 100 (91.7%)

Rehabilitation counseling was included in the professions to be ranked and the question was worded as follows: By placing the numerals one through eight beside the professions listed, rank your impression of the social prestige they enjoy with the public. As indicated in Table 15, the rehabilitation counselor's opinion of his own public professional prestige is appallingly low. When we consider that 88.3% of the counselors placed the teacher, nurse, and social worker above themselves, it becomes evident that such perception of their prestige may be one of the most important reasons for the large percentage of counselors wanting to leave the profession if they could. A full third of the counselors (33.7%) ranked the nurse as occupying first place in the public prestige hierarchy. From the stand-point of college training, the rehabilitation counselor is usually superior to the nurse, yet the counselor rates himself below her. This feeling of prestige inferiority may derive from the fact that the nurse, in dealing directly with sick patients, works more closely to the medical role with the patient and associates more closely with the doctor.

In reviewing the findings, two interpretations must be considered. Assuming counselor perception of his public prestige to be accurate, personnel in the field of rehabilitation are failing in an alarming way to present a positive public image. Should counselor perception of public prestige be less than that of the public, one would be forced to conclude that counselors have strong feelings of professional inadequacy. Finally, what is the relationship between a counselor's ability to help a client and to communicate confidence on the one hand and his own feelings of professional self-worth on the other.

Counselors were emphatic in expressing that the lack of public and professional prestige of their profession was due to the failure of the state rehabilitation agencies to launch adequate public relations programs in which the social, emotional, and economic values of rehabilitation were stressed. They agreed that in certain isolated instances this was done but never on a statewide or nationwide basis. They also felt that in any public information concerning rehabilitation its function and value was discussed in a very general way. The process was never made explicit. Respondents commented that rarely, if ever, was the role of the rehabilitation counselor explained to the public in any detail. As one counselor remarked:

> Much more should be done to make the public aware of the purpose and function of vocational rehabilitation. Just reporting how many people were rehabilitated in a given year is not enough. We need more publicity. It should be constant, and it should be intensive. The role of the rehabilitation counselor should be exploited to the public. Most people including a number of educated ones will ask me, "What is a rehabilitation counselor?" My own agency does very little about publicizing what we do. Sometimes I get to feel very lonely about the whole thing; like nobody knows who I am or what I do. This bothers me because I think what I do is pretty important.

A major variable determining an individual's relationship to his professon and his commitment to it is the reason he initially entered it. While it is true that a person's selection of a profession is influenced by a constellation of factors which are economic, social, and intrapsychic in character, there is often one primary consciously arrived at reason which affects his final choice. Table 16 below shows the distribution of counselor response to the question of what constitutes the most important reason for their entering the profession of rehabilitation counseling.

TABLE 16

Most Important Reason for Counselor Entry Into the Profession of Vocational Rehabilitation Counseling

Reason	*Per Cent*
Salary	8
Civil service rating	8
Desire to pioneer new field	17
Interest in working with handicapped people	34
Commitment to value of rehabilitation to the community	4
Religious or humanistic values	13
Social prestige of a medically related profession	4
Advice from a professional person	5
Available traineeship	7

N = 100 (91.7%)

The reasons for the rehabilitation counselor's entry into the profession can be divided roughly into three different categories or groups. Salary, civil service rating, and available traineeship can be classified as reasons which are essentially material. Interest in working with handicapped people and social prestige of a profession related to medicine can be classified as reasons stemming from intrapsychic needs. The desire to pioneer a new field, the value of rehabilitation to the community and other altruistic reasons can be classified as religious or humanistic. Coming into the field because of advice or persuasion from some professional person could be assigned to any of the three categories depending upon the situation. Classifying reasons in this manner we find that:

1. Twenty-three percent entered the profession for some type of material reason.
2. Thirty-four percent entered because of humanistic or religious values.
3. Thirty-eight percent entered to satisfy emotional needs within themselves.

It has been a common assumption that because rehabilitation counseling has been a profession with comparatively low remuneration, the people who entered it did so because of motives of altruism and dedication. Yet the findings of this study indicate that almost a fourth of the counselors admitted entering the profession of rehabilitation counseling for some material reason. This finding does not have to be interpreted in a negative manner. The fact that counselors enter the profession because of material motives does not mean that they are not competent and productive counselors. Indeed they may well be more effective than dedicated counselors whose major motivation is altruistic. This study has no data bearing on this point. But what can be stated with some certainty is that there is a positive relationship between counselors wanting to remain in the profession and their having come into the profession for some material reason. Table 17 below indicates this relationship.

TABLE 17

Relationship Between Counselor Desire to Leave the Profession and Reason for Entering

	Reason for Entering Profession		
	Material	*Nonmaterial*	*Total*
Would leave rehabilitation counseling profession	17	22	39
Would not leave rehabilitation counseling profession	10	49	59
Total	27	71	98

Chi Square = 8.35, df 1, $p < .01$

If a substantial number of rehabilitation counselors enter the profession for material reasons as is indicated by these findings, this fact should be taken into consideration in the formulation of policies and procedures in counselor recruitment. The financial motive is a fact of life in our culture and must be reckoned with in attracting capable counselors.

If the findings in this study reflect the true motivation of the rehabilitation counselor for entering the profession, then over one-third enter because of their own needs to work with handicapped people. It is recognized that most people try to select a vocation which will satisfy their emotional needs, and this need satisfaction is frequently the basis for an adequate vocational adjustment. Yet, in the counseling professions there is always the danger that the counselor without consciously realizing it will seek to satisfy his own emotional needs at the expense of the best interests of the client. For example, the danger of overidentification or overinvolvement in the client's problems may sometimes be present in those counselors who have chosen the profession because of a particular interest in working with handicapped people. Although it is important for counselors to be dedicated, it is necessary to screen carefully candidates for counselor training and eliminate any whose own needs are so strong as to interfere with their performance in the counseling relationship.

Apparently level and quality of education and training for the profession is an important factor in influencing the counselor's relationship to his profession. If he feels that his training has been adequate, he may be expected to feel security in his competency. The findings of this study demonstrate that a higher level of training contributes to his feeling of professional prestige. When asked to rank in the order of their importance those attributes which increase the public prestige of a profession, the requirement of advanced graduate degrees as part of training was ranked first by 38.2% of the counselors. Counselors also view high salaries as next in importance to educational requirements. Table 18 indicates the distribution of responses. Thus there is a strong suggestion that education and remuneration are seriously considered by the counselor in the development of his professional self-image—a self-image which influences his relationship to the profession and his ability to motivate his clients.

The importance of the counselor's evaluation of his training in influencing his relationship to the profession is suggested by considera-

TABLE 18

Counselor Ranking of the Effectiveness of Certain Attributes in Increasing the Public Prestige of a Profession

	Per Cent of Counselors for Each Rank			
Attributes	1	2	3	4
High salaries	27.2	32.0	24.3	16.5
The requirement of advanced graduate degrees as part of training	38.2	27.6	22.9	11.4
State licensing or certification	19.4	23.3	31.1	26.2
Private practice	15.7	16.7	21.6	46.1

N = 103 (94.5%)

tion of the relationship between the rehabilitation counselor satisfaction with professional training and his desire to remain in the profession. Table 19 reflects this relationship. Since the chi square has a probability of .10, this finding is not presented as significant but as reflecting a trend in the relationship between professional satisfaction and satisfaction with professional training.

TABLE 19

Relationship Between Counselor Satisfaction with Training and Desire to Leave Profession If Financially Able

	Would leave profession if financially able		
	Yes	*No*	*Total*
Satisfied with professional training	9	24	33
Not satisfied with professional training	29	36	65
Total	38	60	98

Chi Square = 2.77, df 1, $p < .10$

It should be noted that rehabilitation counselors who are discontent to the point of considering leaving the profession if they were able look to other professions as having training sequences which better fit their practitioners to carry out their role than does their own profession. (See Table 20.) The data indicate that the counselors who would leave the profession of rehabilitation counseling feel that the school guidance counselor is better trained for his role than they. This finding reflects that counselors who are poorly related to their profession are dissatisfied with training. Since there is a great deal of social, economic, and educational distance between rehabilitation counseling and medical profession, there would be little cause for concern if these counselors were to compare their training unfavorably with that of medical doctors or psychiatrists. However, for these counselors to have compared their training unfavorably with that of the guidance counselor should elicit some concern since statuswise they are the guidance counselor's peer. Moreover, salaries are similar and there are also similarities in their role. This response on the part of counselors would suggest their feelings of inadequacy relative to their training.

TABLE 20

Relationship Between Counselor Desire to Leave the Profession and Comparison of His Training with that of the School Guidance Counselor

	Best Trained for His Role		
	Rehabilitation Counselor	*School Guidance Counselor*	*Total*
Would leave rehabilitation counseling profession	7	11	18
Would not leave rehabilitation counseling profession	22	9	31
Total	29	20	49

Chi Square = 4.85, df 1, p. < .05

Summary

It was the purpose of this chapter to describe and to some extent to analyze the relationship of the vocational rehabilitation counselor in the state agency to his profession. The findings indicate that the self-image of a substantial group of counselors is questionable and in many cases low. What is of crucial importance is that 40.0% of the respondents in this study would leave the profession if they were able to do so. This means that agencies face a morale problem in their counseling staffs. Such a problem influences not only the effectiveness of the state agency organization but also the rehabilitation counselor's capacity for motivating clients and maintaining the counseling process at a peak success level.

It would appear that two important variables which affect the counselor's relationship to the profession are his perception of his social prestige and his regards for his training. Another important variable may be his attitude toward his employing organization which will be studied in some detail in the next chapter. What must be recognized and accepted is that the findings of his study in regard to the counselor's attitudes toward his profession and his professional self cannot be dismissed lightly. Professional attitudes may influence professional performance. Not all vocational rehabilitation counselors have negative attitudes. However, the percentage of those who admit to having them is sufficient to cause some concern and to warrant further and more intensive study of the problem.

THE REHABILITATION COUNSELOR'S RELATIONSHIP TO HIS EMPLOYING ORGANIZATION

Unlike some counseling professions which engage in private practice, rehabilitation counseling is almost totally dependent upon some organization to provide it with a setting in which to practice. For the most part, vocational rehabilitation counselors are found in rehabilitation centers or state rehabilitation agencies. As an organization, the state rehabilitation agency is a social system with its own set of norms, standards, and values. Although both counselor and agency may have a strong commitment to the same organizational purpose (the vocational rehabilitation of handicapped people), they differ on the means and procedures by which this purpose should be attained. The feelings which the counselor develops about his organization color his relationship to it and affect his ability to work effectively within its social structure. The counselor's own motivation and, consequently, his capacity to motivate his clients are functions of the attitudes he mobilizes toward the organization's rules, methods, procedures, and orientation.

One of the overwhelmingly negative attitudes expressed by counselors in this study was toward the large caseloads which they carried. Fifty-nine per cent of the counselors felt that their caseload was so large that they were compelled to do poor quality work on some of their cases. Twenty-two per cent of the counselors felt that their caseload was so large that it had a depressive emotional effect upon them and affected their work adversely. In other words, 81.0% of the responding counselors felt that their caseload was so large as to have some detrimental effect upon their performance. Seventeen per cent of the counselors classified the size of their caseload as just right, while 2.0% characterized their caseload as too small.

Some of the counselors' comments regarding the size of their caseload are reported below:

> We're forever losing some of our top counselors because of our heavy caseload.
>
> Caseloads are far too large for us to provide the necessary attention which each case requires.
>
> I believe that vocational rehabilitation counselors should not have more than one hundred cases on their load at any one time if the job is going to be done the way it should be done.

> The very heavy caseload (150-250) which we carry and the several county areas per counselor make for a very difficult counseling situation. Counseling on a once-every-two-months basis can never be very effective.
>
> The caseload of the average field counselor is usually too large. In most states there are usually insufficient funds to hire enough staff or give the necessary services required.
>
> I feel that the preponderance of cases which a counselor must carry does not enable him to do an adequate job with any one client. Therefore, I would suggest that the administrators arrive at a happy medium so that the counselor will not be buried in a sea of little brown case folders.

Are there particular characteristics which differentiate the counselors who can tolerate large caseloads from those who cannot? Table 21 presents counselor attitudes toward size of caseload in relation to their desire to remain in the profession. The indication is that those who feel that their caseload is too large plan to remain in the profession, while those who make no complaints concerning the size of their caseload would like to leave the profession.

TABLE 21

Relationship Between Counselor Desire to Remain in Profession of Rehabilitation Counseling and Attitude Toward Size of Caseload

	Caseload Size			
	Just Right	*Too Large*	*Impossibly Large*	*Total*
Would leave profession	11	16	13	40
Would not leave profession	7	43	9	59
Total	18	59	22	99

Chi Square = 10.72, df 2, $p < .01$

This is a most interesting relationship for it indicates that a larger proportion of the counselors who complain about the size of their caseloads have a greater commitment to the profession of rehabilitation counseling than those who quietly accept the heavy work burden. Frequently, counselors who complain are branded by administrators as malcontents and gripers as well as inefficient, and sometimes even lazy. This study shows, on the contrary, that those counselors who express concern with the caseload size may do so because of their anxiety to maintain counseling quality. What can be done and what should be done to control size of caseload is a matter for the consideration of rehabilitation planners and administrators. Recommendations in this area are outside the scope of this study.

No questions were asked the counselors concerning productivity and the quantity-quality relationship. Since this is a highly controversial and emotionally charged area, it was the author's opinion that little in the way of objectivity of response could be obtained within the limits of a mailout data gathering instrument. Yet, in spite of this many counselors introduced the quality-quantity relationship in unsolicited comments. Some of these comments are quoted below:

> Can the counselor continue to get large production and at the same time do more with the severely disabled, the older worker, the marginal worker, etc.?
>
> If we continue to exist mainly to achieve placement figures on paper, I think that recording should be graded so that the rehabilitation of a very difficult badly handicapped person would be a high credit. This would encourage a tendency for counselors to spend time with the cases needing the most help instead of being forced to keep grabbing the easy ones in order to hold their jobs.
>
> Vocational rehabilitation seems to be losing its former high degree of orientation to the client and becoming too involved with methodology and statistics.
>
> There is too much emphasis on quantity not quality; by this I mean that emphasis seems to be placed on the number of cases placed rather than the quality of the work done in the cases accomplished.
>
> If the counselor is ranked on the number of rehabilitated cases he has, the pressure of closures overrules good rehabilitation.
>
> I believe the emphasis on numbers rehabilitated has prevented rehabilitation counseling from becoming a true profession.
>
> I feel that if we could go for quality instead of quantity and eliminate the constant harassment of political pressure, the professional rehabilita-

tion counselor would be able to perform a competent and self-satisfying service.

The key role relationship in the state vocational rehabilitation agency is one which exists between supervisor and counselor. To the supervisor falls the responsibility of determining procedures for allocating work assignments as well as rewards. He must function as an intermediary between the administrative echelon of the agency and the counselor on the practice level. In many instances he is a recipient of negative interpersonal communication from levels both above and below him in the status hierarchy. Moreover, to him falls the task of harmonizing and integrating antagonistic forces so as to prevent breakdown in the processes of organization.

Since the supervisor in the state vocational rehabilitation agency is in a position to exercise a telling amount of control over the counselor's activities, the counselor's attitudes toward him and the process of supervision in general loom as important factors in the determination of counselor motivation. One aim was to investigate how counselors perceive the supervisory process and how their perception of this process is related to their feelings of professionalism. Comments by rehabilitation counselors indicate that they see the supervisory role in vocational rehabilitation as consisting of three different but closely related activities:

1. Administration
2. Teaching caseload management
3. Teaching rehabilitation casework (the counseling process)

When asked what they thought the principal role of the supervisor in the rehabilitation agency should be, counselors responded as shown

TABLE 22

Counselor Conceptions of Principal Supervisory Role

Principal Supervisory Role	*Per Cent*
Teacher of rehabilitation counseling techniques	14.3
Teacher of caseload management	28.6
Administrator	57.1

N = 105 (95.4%)

in Table 22. These findings are consistent with a trend which appears throughout this study; namely, the counselor's desire for a higher degree of professionalism which is characterized by functional autonomy. The counselor wishes the supervisor to function primarily as an administrator who provides him with the facilities, the work climate, and the structure within which he can counsel.

The principal role of the supervisor as that of administrator is even more heavily stressed by those counselors who want to stay in the field of rehabilitation counseling. (See Table 23.) This perception of the supervisor is understandable in the light of the counselor's quest for professionalism. The rehabilitation counselor is seeking increased professional prestige, better training, and greater professional authority. The counselor with these needs would tend to put a premium on the value of professional autonomy and less supervisory control of his caseload.

TABLE 23

Relationship Between Counselor Conception of Supervisory Role and Desire to Leave the Profession

	Role of Supervisor		
	Teaching caseload management	*Administration*	*Total*
Would leave profession	17	16	33
Would not leave profession	13	39	52
Total	30	55	85

Chi Square = 6.21, df 1, $p < .02$

Another question frequently posed in the field of vocational rehabilitation is should the responsibility for case supervision (the teaching of rehabilitation counseling) and administrative supervision be vested in the same supervisor. Forty-two per cent of the respondents were of the opinion that a good supervisor in the state agency was capable of adequately fulfilling both functions. On the other hand, 58.0% of the counselors felt that very few supervisors could handle both administrative and counseling supervision. Comments by the counselors reflected a feeling that although the two activities were related, they required a different type of skill. In addition, it was clear that, in the minds of some, administrative supervision and counseling supervision were based on different value orientations which in certain areas are divergent and even antithetical. In general, counselors gave the impression that administrative supervision was based on a philosophy of efficiency, while counseling supervision was based on a philosophy of effectiveness. It was apparent that they felt that under the pressures of administrative demands from higher echelons, supervisors might subordinate counseling supervision to and sacrifice counseling procedures for administrative expediency.

Table 24 focuses attention on the relationship between counselors wanting to leave the profession of rehabilitation counseling and their belief that counseling and administrative supervision should not be carried out by the same supervisor.

TABLE 24

Relationship Between Counselor Belief that Administration and Supervision be Vested in Same Supervisor and Desire to Leave Profession

	Dual Supervisory Role		
	Yes	*No*	*Total*
Would leave profession	13	27	40
Would not leave profession	33	29	62
Total	46	56	102

Chi Square = 4.22, df 1, $p < .05$

Most counselors who would leave the profession of rehabilitation counseling want to move into a field which is more professionalized — particularly psychiatry or psychology in which the interpersonal or psychotherapeutic relationship is prized as (see Table 14) the primary professional tool at their command. Thus, these counselors would be most concerned with the interpersonal aspects of rehabilitation counseling and might want to be supervised in this process by an individual whose major commitment was to the supervision and teaching of the actual counseling process in rehabilitation.

The assumption that the counselor is seeking increased professionalism is reinforced when counselor opinion concerning the role of the supervisor is related to the amount of time counselors think should be spent with the severely handicapped case with a doubtful prognosis.

Table 25 describes the rehabilitation counselor who would spend less than 20.0% of his time on severely disabled clients with doubtful prognoses as viewing their supervisors in an essentially administrative role. These counselors tend to be placement oriented rather than psychotherapeutically oriented.

TABLE 25

Relationship Between Time Spent with Cases of Doubtful Prognosis and Conception of Supervisory Role

	Role of Supervisor		
	Teacher of rehabilitation counseling techniques	*Administration*	*Total*
20.0% or less	8	49	57
Over 20.0%	5	7	12
Total	13	56	69

Chi Square = 4.95, df 1, $p < .05$

Even the manner in which the rehabilitation counselor relates to the paper work in his agency is conditioned by his concern about increasing his degree of professionalism. Seventy-four per cent of the counselors stated that they felt overburdened with administrative details and paper work. Twenty-six per cent felt no excessive burden of administrative or paper work. However, the major concern of the counselors was not merely the use of their time to do paper work, but rather that they as professionals were being compelled to do work which should be done by clerical workers. As one counselor put it:

> My agency has many needs, but our most desperate need is a simple need — more clerks.

2

Another counselor stated:

> The paper work which we must do is time consuming and repetitious.
>
> It's a necessary evil, but it certainly cuts down on the efficiency of any professional person. I am ready to admit that some forms require the judgment of a professional person. However, many do not and are consuming valuable professional time.

One solution to this problem may be the use of rehabilitation counselor aides or assistants. This solution has been experimented upon with success (29).

Summary

It would appear that the counselor's relationship to his state vocational rehabilitation agency is conditioned by his strivings for greater professionalism. He perceives professional standards as being determined by two essential factors. One is the opportunity to spend sufficient time with each client to insure the attainment of the maximum level of rehabilitation regardless of the severity of disability. The other is the allowance by his agency of a high degree of professional autonomy. Attitudes of the rehabilitation counselors indicate that their state agencies as employing organizations are often structured in a manner which does not permit the attainment of these professional standards at a satisfactory level.

THE REHABILITATION COUNSELOR AND THE COMMUNITY SYSTEM

In the final analysis, rehabilitation of the handicapped client takes place not in the agency but in the community social system. His social, emotional, and vocational adjustments take place not in the office of the counselor but rather out in the real world. Therefore, the extent to which the counselor is able to mobilize the community's resources in the client's behalf may be one of the basic determinants of the success or failure of rehabilitation. In mobilizing resources of the community, it is necessary for the counselor to enter into interpersonal relationships with other professionals which are negotiative in character. One aim of this study was to investigate counselor attitudes toward professionals in other disciplines with whom they must enter into cooperative relationships. Table 26 shows the percentage of counselors who rated the various professionals with which they work as most and least cooperative.

The majority of counselors who responded felt that social workers were the most cooperative with them, while medical doctors were the least cooperative. The validity of counselor perceptions of the degree of cooperativeness of their team members is difficult to determine or assess. However, what may be said with some certainty is that these perceptions influence the capacity of the rehabilitation counselor to work effectively with these members of other professions.

TABLE 26

Counselor Ratings of Professionals on Cooperation

Professionals	*Most Cooperative*	*Least Cooperative*
Medical Doctors	15.4%	32.3%
Psychiatrists	12.1	26.0
Educators	16.5	17.7
Psychologists	24.2	2.1
Social Workers	31.9	21.9
	N = 91 (83.5%)	N = 96 (88.1%)

When counselors were asked to rate these same professionals on efficiency in working in the rehabilitation field, the results were considerably different, in fact, reversed. Medical doctors who were perceived by a majority of counselors as least cooperative were judged as highly efficient by a large percentage of those responding. Social workers, on the other hand, who were perceived as most cooperative, were rated as least efficient. Table 27 below shows the distribution of counselor ratings of the professionals on efficiency.

TABLE 27

Counselor Ratings of Professionals on Efficiency

Professionals	*Most Efficient*	*Least Efficient*
Medical Doctors	33.0%	11.6%
Psychiatrists	13.8	22.1
Educators	2.1	32.6
Psychologists	39.4	1.1
Social Workers	11.7	32.6

N = 94 (86.2%)

When rehabilitation counselors were questioned concerning the profession with which they found it easiest to communicate, they gave social work the highest rating and medicine the lowest. Table 28 shows the counselor ranking of the professionals on ease of communication. Barry and Malinovsky (2) cite strong allegiance to one's professional discipline as a possible important factor in poor interdisciplinary communication in the field of rehabilitation. Social workers are trained to regard conference with other community agencies as a treatment tool which they must learn to utilize skillfully for the benefit of their clients. Doctors, in contrast, spend more of their time in direct contact with their patients and occupy the healing role rather than the role of mobilizer of other healing professions. Thus, less of their time is spent in exchanging information with other professions.

Communication, cooperation, and efficiency are crucial variables in maintaining the effectiveness of the rehabilitation process. Olshansky and Margolin (28) state the concept succinctly:

> If the client should be viewed as part of a social system, so should the

> counselor. He is not operating as an individual entrepreneur, though often he may feel as if he were. He is deeply involved in an agency system relating always to other counselors, to supervisors, to administrators and to personnel in other agencies as they impinge on his agency. For him to function efficiently he has to share and feel that others within the system share the same goals and values.

Margolin (23) is of the opinion that conceptualization of the rehabilitation process as taking place only within the framework of the client-counselor relationship can serve to block effective rehabilitation.

TABLE 28

Counselor Ratings of Professionals on Ease of Communication

Professionals	*Easiest to Communicate with*	*Most Difficult to Communicate with*
Medical Doctors	9.4%	35.4%
Psychiatrists	15.6	26.0
Educators	11.5	17.7
Psychologists	24.0	1.0
Social Workers	39.6	19.8

N = 96 (88.1%)

Summary

The data collected in this chapter indicate a tendency of rehabilitation counselors to evaluate their relationship with medical doctors in a negative way. This negative attitude suggests a number of possibilities:

1. The lack of cooperation by doctors with rehabilitation may be reality.
2. It may be an unrealistic or exaggerated perception of the counselors engendered by a professional status difference which produces inferiority feelings and causes the counselor to react with increased sensitivity.

3. Difficulties in communication may stem from the counselor's inability to interpret rehabilitation problems to the doctor.

Whatever the reason, this study does point out that a substantial number of rehabilitation counselors in the state agencies studied do have some feelings of discomfort in their relationships with doctors with whom they are called upon to work cooperatively. Thus, the counselor-doctor relationship is an appropriate area for further research in terms of both degree and kind of problems which might exist.

CONCLUSIONS

This study attempted to analyze the attitudes of state rehabilitation agency counselors toward their profession, their employing agency, and members of other professional disciplines who function as part of the rehabilitation team. Questionnaires were sent to all the counselors in the six New England state agencies. Of the 137 questionnaires sent, 114 or 85.0% were returned. Data was analyzed by cross-tabulation and significance established using the chi square test. Another source of data were the unsolicited comments which counselors included with their questionnaires.

The data collected in this study characterize the rehabilitation counselor in the state agency as a member of an occupational group which is searching for a professional identity. This quest for identity results from a lack of standards for role definition. There is marked variation among rehabilitation counselors in the perception of their role. However, role perception can be classified in one of two major categories:

1. The counselor perceives himself as a type of psychotherapist with the responsibility of helping the disabled person achieve an adequate total life adjustment.
2. The counselor perceives himself as a manipulator of the environment with the major goal being return of the client to employment.

There is a tendency for the majority of counselors to perceive themselves as occupying a psychotherapeutic role with their clients because such a role is linked to the professional prestige of the psychiatric or medical profession. The professional self-image of the rehabilitation counselor is one of low prestige. The counselor utilizes certain mechanisms to bolster his professional self-esteem. These mechanisms are:

The development of demands for individual functional autonomy in the counseling process as opposed to close case supervision.

The adoption of the medical and psychological professions as reference groups.

The demand for more training in dynamic psychology.

The demand to work on fewer cases to insure counseling quality.

The great concern with the quantity-quality relationship and the counselor's concern with professional ethics.

The self-depreciating attitude evidenced by the rehabilitation counselor in the state agency in regard to his professional prestige can pose morale problems. The finding that 40.0% of the rehabilitation counselors sampled would leave the profession if they could is certainly cause for some concern and merits further detailed investigation.

Contributing to this deflated professional self-image is the counselor's feeling that state agencies do not provide them with the wherewithal to accomplish their job in a professional manner. Large caseloads, clerical tasks, concern with quantitative productivity, and inadequate public relations programs are seen by them as roadblocks to their achievement of a high degree of professionalism.

There is certainly room for some concern if the results of this study are viewed in the light of the counselor's ability to motivate his clients. The client's motivation cannot be divorced from the counselor's motivation. Counselors with negative attitudes toward their profession and toward their employing organization may well have difficulty in adequately motivating their clients in the rehabilitation process. It is reasonable to expect that a counselor who suffers from a depreciated self-image may well have difficulty in communicating confidence to a client in rehabilitation. Clients in the rehabilitation process must have faith in the ability of their counselors to help them. Can a counselor with feelings of inadequacy concerning his training and concerning his stature among other professions project a feeling of competency? On the other hand, a counselor may have a very high image of himself professionally but may be very hostile to his agency because of certain existing conditions which he feels thwart his professional development. Can such a counselor refrain from communicating some of the hostility he feels for his agency? Can he refrain from displacing it onto his client? He may do both without ever being conscious that these processes are ongoing.

The writer does not imply that these findings can be generalized to counselors in other parts of the United States. This may or may not be true. Only replication of this study in other regions can determine this fact. However, our sampling was sufficiently broad to state that the findings are applicable to New England counselors. It is not the purpose of a study such as this to make recommendations. Each agency is different and specific recommendations are more a function of consultation rather than of broad research. However, one implication of this study is that well-structured research is desperately needed in two areas: one, on the role of the vocational rehabilitation counselor in the state agency; and two, on the training and administrative climate in which he works. Knowledge gained through such research represents a possible avenue to increased qualitative and quantitative performance as well as to increased professionalism for the vocational rehabilitation counselor.

APPENDICES

APPENDIX A

QUESTIONNAIRE

NEW ENGLAND REGIONAL REHABILITATION INSTITUTE

Northeastern University

Boston, Massachusetts

INSTRUCTIONS: The following questions can be answered by placing a check mark beside the appropriate response. A few require a word or a short sentence as an answer. Please try to answer these questions as objectively as you can based on your knowledge, experience, and observations.

1. What level of curriculum do you think should be adopted for the training of the professional vocational rehabilitation counselor?
   - ( ) Four-year course leading to the bachelor's degree.
   - ( ) One-year course leading to the master's degree.
   - ( ) Two-year course with field work leading to the master's degree.
   - ( ) Four-year course leading to a doctorate.
   - ( ) No specific course of training leading to a degree, but knowledge acquired in various ways in the vocational world and developed through in-service training programs.
2. If you were designing a curriculum for vocational rehabilitation counselors, which of the following aspects of counseling would you emphasize? Using the numerals 1 through 5, rank the following in the order of their importance.
   - ( ) Psychology of personality functioning.
   - ( ) Knowledge of vocations and employment potential.
   - ( ) Community organization techniques.
   - ( ) Medical knowledge of disability.
   - ( ) Psychological testing.
3. In your opinion whose professional training curriculum best fits them for their professional role?
   - ( ) Social workers
   - ( ) Rehabilitation counselors
   - ( ) School guidance counselors

4. Have you ever had any in-service training in rehabilitation counseling?
( ) Yes ( ) No

5. If your answer to the above was yes, did in-service training help you to do a better job in your rehabilitation counseling?
( ) Yes ( ) No

6. If your answer to question 5 was no, state briefly the reason why not.

7. Are you satisfied with the formal professional training which the rehabilitation counselor receives?
( ) Yes ( ) No

8. If not, state briefly why not.

9. Which of the professional groups do you find most cooperative?
( ) Medical doctors
( ) Psychiatrists
( ) Educators
( ) Psychologists
( ) Social workers

10. Which of the professional groups do you find the least cooperative?
( ) Medical doctors
( ) Psychiatrists
( ) Educators
( ) Psychologists
( ) Social workers

11. Which of the professional groups do you find to be the most efficient?
( ) Medical doctors
( ) Psychiatrists
( ) Educators
( ) Psychologists
( ) Social workers

12. Which of the professional groups do you find to be the least efficient?
( ) Medical doctors
( ) Psychiatrists
( ) Educators
( ) Psychologists
( ) Social workers

13. In your activities as a vocational rehabilitation counselor, which professional group do you find easiest to communicate with?
( ) Medical doctors
( ) Psychiatrists
( ) Educators
( ) Psychologists
( ) Social workers

14. Which of the following professional groups do you find the most difficult to communicate with?
    - ( ) Medical doctors
    - ( ) Psychiatrists
    - ( ) Educators
    - ( ) Psychologists
    - ( ) Social workers

15. By placing the numerals 1 through 8 beside the professions listed, rank your impression of the social prestige they enjoy with the public.
    - ( ) Nurse
    - ( ) Teacher (school)
    - ( ) Rehabilitation counselor (in public rehabilitation agencies)
    - ( ) Rehabilitation counselor (in private agencies such as rehabilitation centers, sheltered workshops, etc.)
    - ( ) Psychiatric social workers
    - ( ) Other social workers
    - ( ) Physical therapist
    - ( ) Occupational therapist

16. Using the numerals 1 through 4, rank the following in the order of their effectiveness in increasing the public prestige of a profession.
    - ( ) High salaries.
    - ( ) The requirement of advanced graduate degrees as part of training.
    - ( ) State licensing or certification.
    - ( ) Private practice.

17. Check the most important reason why you entered the profession of rehabilitation counseling.
    - ( ) Salary.
    - ( ) Job security of civil service rating.
    - ( ) The opportunity to pioneer a new field.
    - ( ) A particular interest in working with handicapped people.
    - ( ) Value of rehabilitation counseling profession to the community.
    - ( ) Religious or humanistic values.
    - ( ) The social prestige of a profession related to medicine.
    - ( ) Advice from a person whose professional opinion you respected.
    - ( ) The availability of a traineeship in rehabilitation counseling.

18. Is there a profession you would rather be in than rehabilitation counseling?
    ( ) Yes ( ) No

19. If yes, what is this profession?

20. If you had the financial resources to train comfortably for a new profession, would you leave the profession of vocational rehabilitation counseling?
    ( ) Yes ( ) No

21. Which of the following do you think should be the principal role of the supervisor in the state rehabilitation agency?
    - ( ) Teaching of rehabilitation counseling techniques.
    - ( ) Training counselors in how to manage their caseloads.
    - ( ) Administrative direction.

22. Do you feel that rehabilitation counseling is a form of psychotherapy?
    ( ) Yes ( ) No

23. Should the responsibility for administration and supervision of counseling be vested in the same supervisor?
    ( ) Yes ( ) No

24. In your opinion, if a client is experiencing problems in his family relationships which are blocking his vocational rehabilitation, which of the following treatment plans is best?
    - ( ) The rehabilitation counselor should use his knowledge of interpersonal relationships to help the client resolve these family problems.
    - ( ) The rehabilitation counselor should refer the client to a social worker in a family service agency.
    - ( ) The client should be referred for a psychiatric evaluation and then on the basis of the findings be worked with by the rehabilitation counselor.
    - ( ) The client should be referred for psychiatric treatment.

25. In your opinion, is psychotherapy a component part of the rehabilitation process?
    ( ) Yes ( ) No

26. Place a plus sign beside the disability with which you most prefer to work. Place a minus sign beside the disability with which you least prefer to work.
    - ( ) Patient with neurological motor impairments (paralyses, etc).
    - ( ) Amputees
    - ( ) Visual handicap
    - ( ) Speech and hearing handicap
    - ( ) Mental illness
    - ( ) Mental retardation
    - ( ) Incapacity diseases (heart, diabetes, TB, etc.)
    - ( ) Disease with intercurrent acute episodes (epilepsy, hemophilia)
    - ( ) Defects in communication (speech, hearing, etc.)

27. Would you state the reasons for your above preferences briefly.

28. Do you think your active caseload is:
    - ( ) Too small.
    - ( ) Just the right size to handle comfortably and carry on good quality of counseling.

( ) Too large to carry on good quality counseling in all your cases.
( ) So staggeringly large that it has a negative emotional effect upon your performance.

29. Do you feel overburdened with administrative details and paper work?
( ) Yes ( ) No

30. In your opinion, does the agency in which you work do enough in educating the public about rehabilitation?
( ) Yes ( ) No

31. Do you think rehabilitation of the severely disabled and chronically ill for independent living (to care for their own daily living needs) is as important as vocational rehabilitation?
( ) Yes ( ) No

32. How much of a rehabilitation counselor's time do you think should be devoted to severely disabled clients whose prognosis for successful vocational rehabilitation is doubtful?
( ) Less than 10%
( ) 10%
( ) 20%
( ) 30%
( ) 40%
( ) 50%
( ) More than 50%

INSTRUCTIONS: Would you please answer the following questions about yourself. If you will note, no name is required.

1. Age:..........................
2. Sex:..........................
3. Number of years in present position:..........................
4. Number of years of paid employment in the field of rehabilitation:..........................
5. List positions held in other than the rehabilitation field.
6. Do you presently work exclusively with the deaf?
( ) Yes ( ) No
7. Do you presently work exclusively with the blind?
8. Education: List briefly your professional training stating all college degrees or special training.

INSTRUCTIONS: If you have any comments pertaining to this questionnaire or to the field of rehabilitation, feel free to write them on the remainder of this sheet.

APPENDIX B1

COVER LETTER FOR FIRST QUESTIONNAIRE MAILOUT

I am writing to request your cooperation in a study which we think will have meaning to you. I know that as a professional person and particularly a professional person in the field of rehabilitation you have been searched, researched, and re-researched.

I also know that you have probably had the frustrating experience of never knowing the results of research studies for which you have given your cooperation.

This study is different. Not only do we pledge ourselves to communicate the results to you, but we also hope to gather knowledge which will contribute meaningfully to the structure, definition, and understanding of the professional role of the rehabilitation counselor.

This questionnaire will require just 15 to 30 minutes of your time and you will be making a contribution of value to the future of the profession of rehabilitation counseling.

It is being sent to all state agency rehabilitation counselors in New England. We think that you will find completing it an interesting experience.

All information you supply will be held confidential and your name is not needed on the questionnaire. As time goes on you will hear more about the New England Regional Rehabilitation Research and Demonstration Institute. It was created to serve the state rehabilitation agencies. As we complete projects, results of our research will be communicated to you.

APPENDIX B2

COVER LETTER FOR FOLLOW-UP QUESTIONNAIRE MAILOUT

Two weeks ago we sent you a questionnaire which sampled attitudes of rehabilitation counselors regarding their professional role.

If you have already sent yours in, please accept our sincere thanks and disregard this letter. If you have not, we would be most appreciative if you could take twenty minutes of your time to complete the enclosed questionnaire.

This study has the approval and cooperation of the directors of all six New England state rehabilitation agencies. Questionnaires have been sent to all counselors in these agencies. Thus far the response has been very good. We are shouting for a 100 percent response.

When the data are tabulated and analyzed, we think you will be interested in knowing how your fellow counselors view their role.

APPENDIX C

CHARACTERISTICS OF THE RESEARCH POPULATION

TABLE 1

Age of Rehabilitation Counselors

Age	*Per Cent*
Under 25	4.6
25 - 29	10.2
30 - 34	18.5
35 - 39	15.7
40 - 44	14.8
45 - 49	16.7
50 - 65	18.5
Over 65	.9

N = 108

TABLE 2

Sex of Rehabilitation Counselors

Sex	*Per Cent*
Male	86.2
Female	13.8

N = 109

TABLE 3

Years in Present Position

Years	*Per Cent*
Up to 3	50.5
4 - 10	33.9
Over 10	15.6

N = 109

TABLE 4

Years in Rehabilitation

Years	*Per Cent*
Up to 3	36.7
4 - 10	34.9
Over 10	28.4

N = 106

TABLE 5

Education of Rehabilitation Counselors

Degree	*Per Cent*
BA or BS	12.3
BA or BS +	39.6
MA or MS	21.7
MA or MS +	20.8
Ph.D	2.8
No degree	2.8

N = 106

TABLE 6

Major Area of Educational Concentration

Area	*Per Cent*
Rehabilitation	23.3
Psychology	8.1
Sociology	15.1
Education	18.6
Guidance and Counseling	9.3
Biology	5.8
Business and Economics	12.8
Other related subjects	1.2
Other subjects not related	5.8

N = 86

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